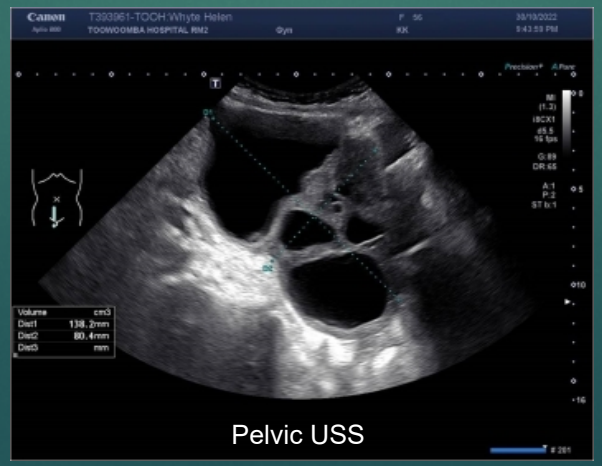
Ovarian cancer; Abdominal bloating and maldigestion are the typical presenting symptoms

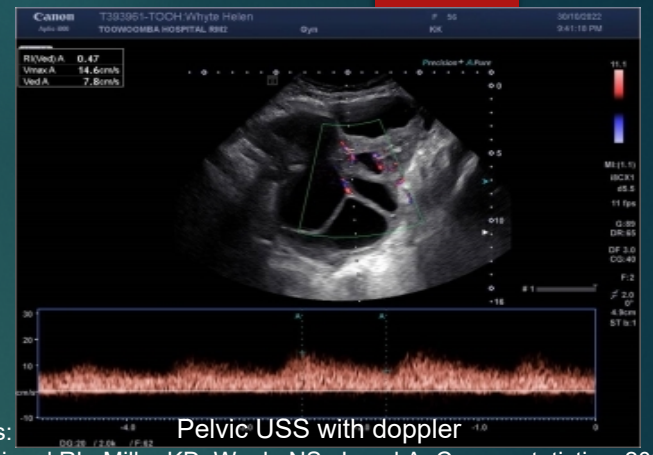
A 56 year-old lady presented to DEM with progressive symptoms of abdominal bloating and discomfort, gastro-oesophageal reflux, difficulty eating and feeling full quickly for two months. On examination, she had soft non-tender abdomen with some distension. Abdo-Pelvic USS showed a large, irregular, multilocular mass in the lower abdomen containing solid and cystic material with ascites; These findings were highly suspicious for an ovarian malignancy using IOTA guidelines. The tumour markers were elevated; CA 125 was 6,782.3, HE4 was 178 and ROMA Postmenopausal was 97. CT scan of chest abdo-pelvis revealed features of epithelial ovarian cancer with peritoneal nodularity and extensive omental spread with ascites. Targeted abdominal USS showed a large mass in the pelvis measuring 16 x 10 x 9cm with a small amount of ascites present throughout the abdomen; Bilateral pleural effusions were also noted. CXR revealed a small to moderate volume left pleural effusion with associated left basal atelectasis/consolidation; Small right pleural effusion and no evidence of pulmonary oedema or pneumothorax. The patient was referred urgently to gynaeoncology. MRI was consistent with stage 3B disease (peritoneal and para-aortic lymph nodes involvement) .PET scan showed no distant metastasis. chemotherapy was commenced (six cycles). CT scan of chest abdo-pelvis was performed after the third chemotherapy cycle and findings were in keeping with partial treatment response with resolution of ascites, reduction in the peritoneal nodularity and reduction in the solid components within the mixed cystic and solid pelvis mass and no new metastasis. She had open hysterectomy, bilateral salpingo-oophorectomy (Rt ovarian tumour), omental biopsy and regional lymph nodes dissection in addition to ascites cytology. The histopathology studies confirmed high-grade ovarian serous adenocarcinoma, omental and regional lymph nodes metastasis with positive tumour cells on ascites cytology.

Discussion:

Ovarian carcinoma is the second most common gynecologic malignancy (second to uterine carcinoma) and the most common cause of gynecologic cancer death in resource-abundant countries[1]. The majority of ovarian malignancies (95 percent) are derived from epithelial cells[2]. Epithelial carcinoma of the ovary (High-grade serous carcinoma is the most common histologic subtype), fallopian tube and peritoneum are considered a single clinical entity due to their shared clinical behavior and treatment and referred to as epithelial ovarian carcinoma EOC. The median age at diagnosis of ovarian cancer is 63 years old (the highest incidence from age 55 to 64 – 24.7%)[3]. Premenopausal ovarian cancer and/or family history of early breast or ovarian cancers in 1st degree relatives (paternal or maternal side) warrant genetic referral for BRCA1 and BRCA2 gene mutation carrier status. 97% of ovarian cancer patients present at advanced stage disease[4]. Advanced epithelial ovarian cancer typically presents with abdominal distention, nausea, anorexia, or early satiety due to the presence of ascites and omental or bowel metastases[5]. Physical examination and abdo-pelvic USS are important element of the evaluation of EOC. CA 125 is a sensitive tumour marker in postmenopausal ovarian masses. Up to 80 percent of patients with EOC will have an elevated CA 125, and post-treatment CA 125 testing is used to evaluate for response to treatment and recurrence [6]. Preoperative assessment for metastatic disease (CT scan of chest abdo-pelvis, MRI abdo-pelvis and PET scan) helps the surgeon anticipate the need for cytoreduction and identify patients who are poor candidates for aggressive initial surgical cytoreduction due to imaging findings of extensive disease (stage 3 and 4) and may be candidates for neoadjuvant chemotherapy[7]. Primary surgical cytoreduction and sending the specimen for histopathological studies followed by systemic chemotherapy is the preferred initial management for women with stage III or IV EOC[8]. Following all first-line treatment for EOC, monitoring should include periodic history taking,physical assessment, CA 125 level monitoring and other testing if clinically indicated (eg, imaging or laboratory assessments) [9]. Five-year survival of stage 3 EOC is 41% [10].



Pelvic USS



Pelvic USS with doppler

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